Question #	Question	Answer
1	AHCCCS has asked that existing contractors do the following: 1. Ignore the specific demographic and health status of their existing business 2. Bid based on an assumption of "average" demographic and health status …on the assumption that risk adjustment will retrospectively correct the rate for the specific population that the contractor serves. Since the actuaries cannot attest to the adequacy of the risk adjusted rates (because there is no guidance on how rates will be adjusted), they must attest that the bid rate is adequate. Given that existing contractors are essentially being asked to not use their own experience, the actuary is being asked to attest that IF the plan's membership were different than it currently is (as in, reflective of the AHCCCS "average"), THEN the bid rates would be sufficient. Since the average cost per member (a proxy for health status), as presented in the data book, already reflects a mixture of savings related to contracting and medical management efforts by individual existing contractors, how should bidders define "average" health status?	AHCCCS defines average for purposes of bidding as equivalent to the data presented in the databook, which does reflect savings related to contracting and medical management. It is up to the Bidder to determine if their contracting and medical management differ from that presented in the databook.
2	Since contractors will never be reimbursed based solely on the rates they are bidding, has AHCCCS considered publishing the ranges and allowing bidders to bid within those ranges?	No.
3	The data book presents data that includes unit cost savings and the impact of medical management efforts for all plans combined. Bidders do not have information available in sufficient detail in the databook to determine the base from which they will adjust to reflect their own anticipated medical management and unit cost levels. Actuaries will therefore be certifying bid rates intended to reflect "average cost" members with significantly incomplete information. For actuaries to certify, the limitations in the data must be specified in the certification. Will AHCCCS acknowledge that the inclusion of such qualifications in the actuarial certification is acceptable and will not be evaluated negatively when the proposed rates are scored?	AHCCCS will allow qualification statements in the actuarial certification and the Offeror will not be evaluated negatively as a result.
4	Risk adjustment assumes contactors will bid on a level playing field, i.e. average demographic and health status, producing equivalent medical cost ratios, except for contracting and medical management initiatives. 1. Will the starting point for risk adjustment be the rate bid by the individual contractor? 2. Given that there is no assurance that bidders will bid as instructed in Amendment #4, will contractors be reset to the "average" that AHCCCS has directed them to bid at?	1. Risk adjustment will be applied to the awarded rates. 2. No.

5	In what format does AHCCCS want the amendment #4 submission? Is the bidder required to submit 8 copies of the amendment #4 submission? Does it need to be in a new binder, what size binder, How are the pages to be numbered, in sequential order from previous submission, start over at page number 1, or use the same pages numbers from the previous submission? What if there are fewer or additional pages than the previous capitation submission?	The Offeror should follow the original RFP Instructions in Section I and submit one (1) original and seven (7) copies of each response. The responses should be submitted separately in binders or three ring report covers (size permitting). Offeror's should number the submission pages starting with the next number available after the original submission starting with Amendments 3, 4, and 5 then Attachment J2, followed by a table of contents and submission requirements 12, 72 and 73. For example, if the last page in the original submission to question 76 was page 1192, the April 18th submission would start with the page 1193.
6	Does AHCCCS want a new original signed amendment #3 signature page and copies included with amendment #4 submission if the Contractor already submitted the amendment #3 signature page in the contractors March 28 submission?	Signature page should be included with the submission of Amendments #4 and #5 on April 18, 2008.
7	Will AHCCCS be updating Attachment J (2) to include the Amendment #4 signature page?	Yes an updated Attachment J will be a component of Amendment #5.
8	The bidders have incurred a significant expense to develop and submit the capitation rates as was previously required by the March 28, 2008, 3 pm deadline. The bidders will now have to redo this work and incur these additional costs. Will AHCCCS be reimbursing the bidders for the cost of having to perform this work twice?	No.
9	AHCCCS has stated that they will share further risk adjustment model methodology details with the Contractor prior to implementation. At this point the Contractors have no details on how these risk factors will be developed and applied to the capitation rates that the Contractors are bidding. How can Contractors build accurate and reliable financial forecasts not knowing the impact of these risk factor adjustments, especially when Amendment #4 provides language to retroactively apply these rates back to October 1, 2008 as they are not provided to the Contractor until April 1, 2009? Because we are part of a publicly traded Company, how can we issue accurate financial statements to regulatory agencies and investors when we do not know how these risk factors adjustment will impact the Health Plan?	Bidder's should submit their forecasts using their bid rates as a base and adjusting that base if the bidder feels it necessary based on their own experience/anticipated acuity adjustment and/or based on anticipated adjustments for network/new contracts, etc. All assumptions used should be supplied to AHCCCS as part of the submission. As part of the implementation of the risk adjustment methodology, AHCCCS will involve the Contractors early and regularly to discuss the methodology and its application. This may include sharing preliminary adjustment results. As part of this process, the Contractors should be able to arrive at an estimated overall risk adjustment that will be applicable to their plan, thus allowing the financial statements to reflect a payable/receivable to/from AHCCCS in order to provide accurate financial statements.

10	How does AHCCCS anticipate scoring or grading questions #72 and #73 when there is so much uncertainty about the impact of the risk factor adjustments and their impact on the financial results of the Contractors?	AHCCCS will not disclose the scoring and evaluation criteria beyond what has been provided.
11	Amendment #4 and the implementation of the risk factor adjustments has caused a significant amount of uncertainty around the financial soundness of the capitation rates and financial forecasts for the Contractors. Has AHCCCS considered that qualified actuaries may not be willing to certify the capitation rates because so much uncertainty exists around the risk factor adjustments?	See answer to question #3.
12	How is the Contractor expected to determine the average monthly cost of an enrollee who has average demographic and health status when AHCCCS is not providing the Contractor with the specifics on how the risk adjustment model will be determining the average monthly cost of an enrollee who has average demographic and health status?	See answer to question #1.
13	Can AHCCCS explain why there is a need to change the RFP requirements for the following statements: Bid rates by GSA and risk category reflecting the expected average monthly cost of an enrollee who has average demographic and health status using the data provided by AHCCCS in the bidder's library. Bidders should not take into account their own unique membership demographic or diagnosis experience, but can factor in the anticipated impact of the contractor's unique medical management and/or cost experience. The need to retroactively apply the risk factors back to October 1, 2008. The need to change the phase in of the risk factor adjustment from 50% to 80%. If AHCCCS feels it is not appropriate to explain, why?	At this time, AHCCCS is not disclosing the reason for the amendment.
14	Amendment #4 states, "For CYE 09, AHCCCS will apply approximately 80% of the capitation rate risk factor adjustment." This appears to be some what subjective, will AHCCCS be applying 80% of the risk factor or will AHCCCS use it's discretion to determine the approximate percentage of the risk factor it feels appropriate to apply to the capitation rates?	AHCCCS will apply approximately 80% of the risk factor for each Contractor. Based on the model, it will be as close to 80% as mathematically possible.

15	When will AHCCCS release the methodology details on calculating the risk factor adjustment? The risk factor adjustment has the potential to have a huge impact on the capitation rates and the overall outcome of the bid. Why is such a critical issue being left to a later date?	The risk adjustment model currently being tested by AHCCCS uses diagnostic and procedural information from medical and pharmacy encounters as well as demographic data. The model generates individual health risk scores based on risk adjusted episodes of care created by a grouper. For the experience period selected, risk scores will be combined for all individuals in the risk group (by GSA and Contractor). These risk scores will be used in the development of risk factors to be applied to the awarded rates. AHCCCS plans to apply a prospective model which will use recent historical data for a base time period to measure risk for a future time period. The detailed methodology will be made available as part of the process mentioned in question #9.
16	Because there is so much uncertainty surrounding the impact of the risk factor adjustment methodology and its implications on the capitation rates – will AHCCCS be changing how it scores the capitation sections (question 12, 72, and 73)? How can questions 72 and 73 be scored without the impact of the risk factor adjustment? The results of the risk factor adjustments could cause a bidder to fall outside of AHCCCS's financial viability standards.	See answer to #9.
17	Since most plans will determine the admin they need on a PMPM basis and turn this into a % of premium, how are the plans to ensure that they will get the admin that they need if the rates that they bid are not the ultimate rates that they will receive? For example, if the plans load their needed premium into the bid rates but then later AHCCCS determines that their risk score is .95, the plan will be receiving 5% less admin than they need.	AHCCCS will address this issue as part of the discussions with the Contractors during the implementation of the risk adjustment methodology as mentioned in answer #9.
18	Will the risk scores adjusted cap rates multiply the risk score times the plan specific bid or will AHCCCS multiply the risk score times some weighted average bid of all bidders/contractors (or another method all together)?	See answer to #4.
19	If the risk score adjusted cap rates are retroactive to 10/1/08, at the end of 2008, none of the plan's financial statements will accurately reflect their experience for the year. How do you anticipate helping the plans estimate the "settlement amount" that either the plans will owe AHCCCS or that AHCCCS will owe the plans?	See answer to #9.

20	Bidding the average demographic/risk pool requires plans with experience to separate out from their experience what is risk and what are other factors, such as medical management. Without knowing the risk scores, this is extremely difficult to do. Is there any information that AHCCCS can provide, such as the average HEDIS scores by GSA that may help the plans understand the potential impact of their medical management?	Various performance related reports may be found on the AHCCCS website at http://www.azahcccs.gov/Studies/
21	Is it possible to get the state's encounter data, even if it is just the prescription drug data, so that plans can try to run their risk score compared to the state average?	No additional encounter data will be provided other than the data already provided in the databook, which includes pharmacy data.
22	Has AHCCCS considered the possibility that bidding the average demographic/risk population and not using plan specific experience may actually increase the overall cost to the state? Given the added uncertainty, plans may be more inclined to bid conservatively, which will increase the overall cost to AHCCCS? If amendment #4 does cause plans to bid more conservately, amendment #4 will have effectively taken the competitive nature out of the bid process.	Comment noted.
23	Have you done any analyses on risk scores that you can share? For example, do you have a distribution of risk scores by risk group so that the plans can try to understand which risk groups may be minimally impacted by the risk score adjustment and which may have be significantly impacted?	Due to the potential changes in membership mix by Contractor within each GSA and risk group, AHCCCS is not providing detail on the preliminary risk adjustment results. Based on previous actuarial research on risk adjustment results in other mandatory managed care Medicaid programs, the range in risk factors tends to be between .88 -1.12. A majority of the risk factors resulting from preliminary calculations using the model AHCCCS is testing fall within this range.
24	The bidders have already submitted actuarial certifications with their March 28, 2008 – what additional support or certification is AHCCCS requiring from the actuary related to the April 18, 2008 capitation submission.	An actuarial certification of the rates submitted April 18th is required. See also answer to question #3.
25	Will AHCCCS be changing the Solicitation Due Date on Amendment Number Four?	No, the Solicitation Due Date did not change, only the requirements as outlined in Attachment 3.
26	Will AHCCCS be changing the Execution date on Amendment Four?	No. AHCCCS will not be changing the Execution date on Amendment #4.
27	Will AHCCCS be adding the GSA Box for which the Offeror is submitting a bid to Amendment 4?	No. It was included in Amendment #1.
28	Are the Capitation Bids due on 4/18/08 required to be in 3" Binders?	Please see response to question #5.

29	Should the Capitation Bids due on 4/18/08 be paged the same as the original submission? Will AHCCCS be replacing Question 12, 72 and 73 sections?	Please see response to question #5. No, AHCCCS will not be replacing Question 12, 72 and 73 sections (please see Amendment #4).
30	Will AHCCCS be adding Solicitation Amendment #4 signature page to the checklist?	Please see response to question # 7.
31	The Amendment instructs bidders to base their bids on the average expected cost of an enrollee in the GSA, i.e., use the state's encounter data rather than the plan's own historical claims experience. It is not clear to us how to do this and still submit a clean actuarial soundness opinion. If a plan's own experience is materially higher than the encounter data, this would seem to suggest the need for a qualified actuarial opinion. How would AHCCCS view a qualified opinion? Would such an opinion result in disqualification or reduced scoring of a plan's bid?	See answer to question #3.
32	The instruction to bid based on encounter data is a result of AHCCCS' decision to implement a risk adjuster methodology in 2009. AHCCCS states that 80% weight will be given to risk adjusters retroactively to Oct 1, 2008. For a plan with experience PMPMs higher than that suggested by the GSA-wide encounter data, even if we assume that whatever risk adjuster methodology AHCCCS adopts is sound and exactly adjusts revenue to reflect risk profile, there will still be a shortfall. 80% of the excess cost would be funded in the first year, leaving 20% unfunded. How does AHCCCS intend a plan to fund this shortfall? How does AHCCCS intend a plan's actuary to issue an actuarial soundness opinion with a potential deficit built into the state's methodology?	Upon application of the risk adjustment methodology, including the 80% application, the resulting rates will be reviewed to ensure they remain actuarially sound. In the remaining years covered under this contract, 100% of the adjustment will be applied. See also answer to question #3.
33	Will AHCCCS be releasing any information about the risk adjustment model to be used before April 18, 2008?	See answer to question #15.
34	How will the risk adjustment process work? Will risk adjustment factors be applied to bid numbers? If AHCCCS applies approximately 80% of the capitation rate risk adjustment factor to one number during the phase-in period, what number is the other approximately 20% applied to?	See answers to #15 and #32.
35	How can bidders compute expected average costs of an enrollee with average demographic and health status from the data in the AHCCCS Bidder’s Library? Doesn’t that data reflect the unique medical management experience and unique unit cost structures of the incumbent health plans in the GSAs?	See answer to #1.

36	While we support the idea of risk adjustment and believe that the quality of care will improve with a successful risk adjustment payment program, we are concerned about the quick implementation of such a program. Our research indicates that several states have had serious problems with the implementation of risk adjustment payment programs. Studies show that other States have found that the successful implementation of these programs requires the involvement of health plans in the early stages and throughout the implementation process. Another key element for success is the gradual phase-in of the adjustment process, preferably over a two or three-year period. And, finally, risk corridor mechanisms are recommended so as not to create dramatic fluctuations in health plan revenue which could destabilize the entire managed care program. Would AHCCCS reconsider the quick implementation of its risk adjustment program with very little health plan involvement, and consider a longer phase-in with more health plan involvement, no retroactive implementation, and risk corridor protections for the health plans?	Comments noted. See also answer to question #9.
37	We have a serious concern about the actuarial soundness of bidding an average rate without knowing anything about the risk adjustment model that will be used. We believe that an actuarially sound approach for implementing a risk adjustment payment program would involve AHCCCS releasing the risk adjustment model prior to the bidding along with its analysis of how the model will work. AHCCCS should compute and normalize the factors to be used in the risk adjustment payment program and release those factors to the bidding health plans prior to the bidding. We also believe that bidders should know the risk characteristics of the membership in each GSA. Would AHCCCS consider releasing the risk adjustment model along with its own analysis of the risk characteristics of the entire AHCCCS population and extend the bid deadline by at least four weeks in order to allow the health plans to analyze this data and calculate an actuarially sound bid? If not, what happens if a health plan can't get an actuary to certify their bids under the current circumstances?	See answer to #3 and #15.
38	Would AHCCCS accept a qualified actuarial certification that included a proviso that the bids would be adjusted to an actuarially sound basis when the actual risk adjustment model is released and the effects of the model are quantified?	See answer to #3.
39	What period of claims data will be evaluated for the first risk adjustment	The data period is not available at this time.
40	Will future risk adjustments also be applied retroactively?	No, future risk adjustments will be applied on October 1 of each year beginning October 1, 2009.

41	Will health plans have an opportunity to appeal or request changes to the risk adjustment model prior to implementation?	The appeal rights are found in the contract.
42	Will the baseline rates for a health plan be the rates that they bid, or the average of all bids, or some other average?	See answer to #4.
43	Will AHCCCS be changing its FFS and Non Contracted inpatient reimbursement methodology from tier rates to DRG's in order to align risk-based contractor reimbursement to facility payments? If so, what DRG pricing mechanisms will be adopted?	No.
44	A pre-paid, capitated contract to provide healthcare services is essentially a risk sharing arrangement between the health plan and AHCCCS. How can a health plan asses the risk it is taking if it is not able to predict what its revenue will be?	See answer to #9.
45	The reinsurance offsets appear to have decreased substantially from the original offsets. Can AHCCCS provide the reason for the decrease?	The original offsets were built early in the RFP process. With more recent data and trend analysis on hospital inpatient services, we believe it was appropriate to adjust the offsets.
46	AHCCCS indicated that it would be utilizing a national risk adjustment model; can you provide what the name/source of the model is?	See answer to #15.
47	AHCCCS indicated that it would be utilizing a national risk adjustment model; can you provide what variables will be used to determine each member's risk score?	See answer to question #15.
48	AHCCCS indicated that it would be utilizing a national risk adjustment model; will the risk score be member specific (similar to Medicare) or risk pool specific? If member specific, will it follow the member from plan to plan?	See answer to #15.
49	Will AHCCCS provide each health plan an estimate of their risk score relative to the overall risk mix to help develop the bid?	This information will not be provided prior to April 18th. See also answer to #9.
50	How can a health plan estimate how its risk mix is different than the overall AHCCCS average?	This is up to the Bidder to determine.
51	Would AHCCCS consider allowing a health plan to adjust its capitation in the future based on how its actual risk score compares to the risk score assumed in its bid development?	No.

52	Does AHCCCS intend for a health plan to disregard its own experience in the development of a bid?	As stated in the amendment, "Bidders should not take into account their own unique membership demographic or diagnosis experience, but can factor in the anticipated impact of the Contractor's unique medical management and/or unit cost experience."
53	If a health plan's experience deviates from the AHCCCS overall experience, how does the health plan determine if the deviation is caused by a risk mix difference or reasons other than risk mix (ie, provider contracts, medical management) that would continue beyond implementation of the risk adjuster?	This is up to the Bidder to determine.
54	What is AHCCCS' expectation regarding the actuarial certification? Consider the example in which a bid based on AHCCCS claim experience generates a bid that is 10% less than a bid based on the health plan's experience. If the plan is not to take into consideration differences in risk mix, will AHCCCS (and CMS) accept a qualified certification regarding the financial sufficiency of the bid?	See answer to #3.
55	Please provide guidance for the April 18 submission. Should the plan submit 1 original and 7 copies of questions 12, 72, and 73?	Please see response to question #5.
56	Please provide guidance for the April 18 submission. Will AHCCCS require 3 inch binders for each submission? Or can an appropriate sized binder(s) be used?	Please see response to question #5.
57	Please provide guidance for the April 18 submission. Should the health plan re-paginate its responses to questions 12, 72, and 73 based solely on the April 18 submission or should the page numbers correspond to the original submission?	Please see response to question #5.
58	Is an updated CD of the plan's submission required with the changes related to items 12, 72, and 73?	There is no CD required for items 12, 72 and 73.
59	AHCCCS indicated that it would be utilizing a national risk adjustment model; if the model is not member specific, how will AHCCCS take into consideration the change that could occur throughout the year due to (a) members changing health plans at AEC, and (b) changes in the acuity of members new to the AHCCCS program?	See answer to #15. The risk adjustment will be revised based on enrollment as of a certain date once each year.
60	AHCCCS indicated that it would be utilizing a national risk adjustment model; if the model is member specific, what time period of services will be used to determine the member's risk score?	The model is not member specific. See answer to #15.

61	The amendment directs bidders to submit rates by GSA and risk category that reflect average demographics and health status using the data provided in the bidder's library. Because Pima Health Plan was removed from the data book, how will the risk scores account for the incomplete data provided in GSA 10?	AHCCCS will review the impact of the Pima data at the time of implementation of the risk adjustment and make any necessary revisions.
62	What were the base trend rates and leveraged trend rates by GSA and risk group used in calculating the CYE09 reinsurance offsets?	No additional information will be provided.
63	Could you please clarify and give some examples of how a Bidder can factor in "the anticipated impact of its unique medical management and/or unit cost experience?"	This is up to the Bidder to determine.
64	The use of demographic and health status data provided by AHCCCS means that differences in capitation rates among the Bidders will be based solely on how they quantify the anticipated impact of their medical management practices. What is the reason for not allowing each Bidder to use its own membership demographic or diagnosis experience?	The application of the risk adjustment factor will account for the unique membership demographic and diagnosis experience.
65	With regard to using demographic and health status data provided by AHCCCS in the Bidders' Library, is a Bidder supposed to use data specific to its GSA or data that represents an average for the entire state? Presumably, we should use data consistent with what AHCCCS considers to be an average risk for all the Bidders in the GSA.	The Bidder should use data by GSA.
66	What format should questions 12, 72 & 73 be submitted in? Will these be replacement pages inserted into the original submission or a completely separate submission to inc a table of contents and presented in their own binder?	Please see response to question #5.
67	What specific Risk Adjustment model and method will be used to risk adjust the bids? Will AHCCCS consistently apply their model across each rate cell?	See answer to question #15. The methodology will be consistently applied.
68	Does the AHCCCS approach provide calculation of Risk Adjustments scores using a prospective or concurrent weight methodology?	Prospective.